



IDAHO BOATING ACCIDENT REPORT
IDAHO DEPARTMENT OF PARKS AND RECREATION
PO BOX 83720
BOISE ID 83720-0065
208-334-4199



The operator of any vessel involved in a collision, accident or other casualty resulting in death, injury or property damage in excess of \$1,500 must file a Boating Accident Report (67-7027, Idaho Code). Reports in cases of death, incapacitating injury or disappearance must be submitted within 48 hours. Reports in other cases must be submitted within 10 days. All reports shall be submitted to the sheriff of the county in which the accident occurred, and a copy shall be readily transmitted by the sheriff to the State Boating Enforcement Coordinator, Idaho Department of Parks and Recreation.

COMPLETE ALL BLOCKS (Indicate Those Not Applicable by "NA")					
ACCIDENT DATA					
Date of Accident	Time AM PM	Name of Body of Water	Location (Give location precisely)		
No of Vessels Involved	Nearest City or Town	County	State	Zip Code	
Weather (check all applicable)	Water Conditions	Temperature (estimate)	Wind	Visibility	
<input type="checkbox"/> Clear <input type="checkbox"/> Rain <input type="checkbox"/> Cloudy <input type="checkbox"/> Snow <input type="checkbox"/> Fog <input type="checkbox"/> Hazy	<input type="checkbox"/> Calm (Waves less than 6") <input type="checkbox"/> Choppy (Waves 6" to 2') <input type="checkbox"/> Rough (Waves 2' to 6') <input type="checkbox"/> Very Rough (Greater than 6') <input type="checkbox"/> Strong Current	Air _____ ° F. Water _____ ° F.	<input type="checkbox"/> None <input type="checkbox"/> Light (0-6 mph) <input type="checkbox"/> Moderate (7-14 mph) <input type="checkbox"/> Strong (15-25 mph) <input type="checkbox"/> Storm (Over 25 mph)	<input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Poor	
Name of Operator		Operator Address City _____ State _____ Zip _____			
Operator Telephone No. ()	Date of Birth (Mo., Day, Yr.)	Operator's Experience	Instruction in Boating Safety		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Insurance Co	<input type="checkbox"/> None <input type="checkbox"/> Under 100 Hours <input type="checkbox"/> Over 100 Hours	<input type="checkbox"/> State Course <input type="checkbox"/> US Power Squadron <input type="checkbox"/> USCG Auxiliary <input type="checkbox"/> American Red Cross <input type="checkbox"/> None		
Name of Owner		Owner Address City _____ State _____ Zip _____			
Owner Telephone No. ()	No. of People on Board	No. of People Being Towed	Rented Boat <input type="checkbox"/> Yes <input type="checkbox"/> No		
BOAT NO. 1 (This Vessel)					
Boat Registration or Documentation No.	State	Hull Identification No.	Boat Name		
Boat Manufacturer		Length	Model	Year Built	
Type of Boat	Hull Material	Engine	Propulsion	Personal Flotation Devices (PFDs) Was the boat adequately equipped with Coast Guard approved PFDs? (Life Jackets)	
<input type="checkbox"/> Open Motorboat <input type="checkbox"/> Cabin Motorboat <input type="checkbox"/> Auxiliary Sail <input type="checkbox"/> Sail (Only) <input type="checkbox"/> Rowboat <input type="checkbox"/> Canoe/Kayak <input type="checkbox"/> Personal Watercraft <input type="checkbox"/> Pontoon Boat <input type="checkbox"/> Houseboat <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Wood <input type="checkbox"/> Aluminum <input type="checkbox"/> Steel <input type="checkbox"/> Fiberglass <input type="checkbox"/> Rubber/Vinyl/Canvas <input type="checkbox"/> Rigid Hull Inflatable <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Outboard <input type="checkbox"/> Inboard <input type="checkbox"/> Inboard- Stern-drive (VO) <input type="checkbox"/> Airboat	<input type="checkbox"/> Propeller <input type="checkbox"/> Water Jet <input type="checkbox"/> Air Thrust <input type="checkbox"/> Manual <input type="checkbox"/> Sail	<input type="checkbox"/> Yes <input type="checkbox"/> No Were PFDs accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Fuel	No. of Engines	Fire Extinguishers	
		<input type="checkbox"/> Gasoline <input type="checkbox"/> Diesel <input type="checkbox"/> Electric	Total Horsepower	On Board? <input type="checkbox"/> Yes <input type="checkbox"/> No Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Operation at Time of Accident (check all applicable)	Activity at Time of Accident (check any if applicable)	Type of Accident		What Contributed to Accident? (check all applicable)	
<input type="checkbox"/> Cruising <input type="checkbox"/> Changing Direction <input type="checkbox"/> Changing Speed <input type="checkbox"/> Drifting <input type="checkbox"/> Towing <input type="checkbox"/> Being Towed <input type="checkbox"/> Rowing/Paddling <input type="checkbox"/> Sailing <input type="checkbox"/> Launching <input type="checkbox"/> Docking/Undocking <input type="checkbox"/> At Anchor <input type="checkbox"/> Tied to dock/Moored <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Fishing <input type="checkbox"/> Fishing Tournament <input type="checkbox"/> Hunting <input type="checkbox"/> Swimming/Diving <input type="checkbox"/> Making Repairs <input type="checkbox"/> Waterskiing/Tubing <input type="checkbox"/> Racing <input type="checkbox"/> Whitewater Sports <input type="checkbox"/> Fueling <input type="checkbox"/> Starting Engine <input type="checkbox"/> Non-Recreational <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Grounding <input type="checkbox"/> Capsizing <input type="checkbox"/> Flooding/Swamping <input type="checkbox"/> Sinking <input type="checkbox"/> Fire or Explosion (Fuel) <input type="checkbox"/> Fire or Explosion (Other) <input type="checkbox"/> Skier Mishap <input type="checkbox"/> Collision With Vessel <input type="checkbox"/> Collision With Fixed Object <input type="checkbox"/> Falls Overboard <input type="checkbox"/> Falls in Boat <input type="checkbox"/> Struck by Boat <input type="checkbox"/> Struck by Motor/Propeller <input type="checkbox"/> Struck Submerged Object <input type="checkbox"/> Hit and Run <input type="checkbox"/> Other (Specify)		<input type="checkbox"/> Weather <input type="checkbox"/> Excessive Speed <input type="checkbox"/> Improper Lookout <input type="checkbox"/> Restricted Vision <input type="checkbox"/> Overloading <input type="checkbox"/> Improper Loading <input type="checkbox"/> Hazardous Waters <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Drug Use <input type="checkbox"/> Hull Failure <input type="checkbox"/> Machinery Failure <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Operator Inexperience <input type="checkbox"/> Operator Inattention <input type="checkbox"/> Congested Waters <input type="checkbox"/> Passenger/Skier Behavior <input type="checkbox"/> Other (Specify)	
Estimated Speed					
<input type="checkbox"/> Drifting <input type="checkbox"/> Under 20 mph <input type="checkbox"/> 10-20 mph <input type="checkbox"/> Over 20 mph <input type="checkbox"/> Over 40 mph					

DECEASED (If More Than 2 Fatalities, Attach Additional Forms)

Name of Victim No. 1		Address of Victim City State Zip		Was PFD Worn? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Death Caused By <input type="checkbox"/> Drowning <input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Disappearance
Name of Victim No. 2		Address of Victim City State Zip		Was PFD Worn? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Death Caused By <input type="checkbox"/> Drowning <input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Disappearance

INJURED (If More Than 2 Injuries, Attach Additional Forms)

Name of Victim No. 1		Address of Victim City State Zip	
Date of Birth	Medical Treatment Beyond First Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe Injury	
	Admitted to Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was PFD Worn? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior to Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	As A Result of Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was It Inflatable? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Victim No. 2		Address of Victim City State Zip	
Date of Birth	Medical Treatment Beyond First Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe Injury	
	Admitted to Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was PFD Worn? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior to Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	As A Result of Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was It Inflatable? <input type="checkbox"/> Yes <input type="checkbox"/> No

BOAT NO. 2 (If More Than 2 Vessels, Attach Additional Identifying Information)

Name of Operator	Operator Address City State Zip	
Operator Telephone No. ()	Boat Registration or Documentation No.	State
Name of Owner	Owner Address City State Zip	
Owner Telephone No. ()		

PROPERTY DAMAGE

Estimated Amount This boat and contents: \$ _____	Other boat(s) and contents: \$ _____	Other property: \$ _____
Describe Property Damage		

WITNESSES NOT ON THIS VESSEL

Name	Address City State Zip	Telephone No. ()
Name	Address City State Zip	Telephone No. ()

PERSON COMPLETING REPORT

Name	Address City State Zip	Telephone No. ()
Signature	Qualification <input type="checkbox"/> Operator <input type="checkbox"/> Owner <input type="checkbox"/> Other (Specify)	Date Submitted

ACCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED. (Sequence of events. Include failure of equipment. Include a diagram if needed. Continue on additional sheets if necessary. Include any information regarding the involvement of alcohol and/or drugs in causing or contributing to the accident. Include any descriptive information about the use of PFDs.)

FOR IDPR USE ONLY

Causes Based On (Check One) <input type="checkbox"/> This report <input type="checkbox"/> Investigation <input type="checkbox"/> Investigation and this report <input type="checkbox"/> Other (Specify) _____		
Name of Reviewing Officer	Date Received	<input type="checkbox"/> Recreational <input type="checkbox"/> Non-Reportable <input type="checkbox"/> Commercial
Primary Cause	Secondary Cause	